Riding The Waves of Change:
The Case Manager’s Challenge in Pain Management

Case Management Conference 2014

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Disclosure

I have no actual or potential conflicts of interest to disclose
Objectives

• Identify evidence based quality pain management principles for patients with:
  – Acute pain
  – Chronic pain

• Identify pain management protocols, tools and implications
Continuum of Patient Care Between Health Settings

Collaboration Is Essential!
No Medical Problem or Stress is More Prevalent in our Society than Pain

• Pain is complex process
• Understanding process helps select treatment  Arnstein, 2010
• Chronic pain costs $560 to $635 billion annually
• Mean annual health care expenditures
  – $4475 per person; Additional $3210 for severe pain
Pain Management is a Priority

- Effect on outcome
- Effect on quality life
- Health care cost to the individual
- Lost days of work
- Health care cost to society
- Consumers: comfort and pain relief

*Caring for patients begins and ends with comfort*
The Nurse & Pain Management

Patient Needs & Outcomes

Evidence/Best Practices

Hospital Policies, Procedures, Guidelines

Regulatory Agencies

Patient Safety

Nursing Standards & ANA Code of Ethics

The Nurse and Pain Management
Pain Relief—Integral To Health Care

• Must develop/maintain current knowledge of the best pain evidence

• Imperative to provide patient centered care...know the patients we care for
  – What do patients want?
  – What do patients/families need?

• Know the policies and procedures that govern the care you provide

• Patient safety is the driving force!
Promoting Evidence Based Practice

• To improve patient safety and outcomes through analysis of and changes in practice

• To increase clinical knowledge for all care providers
  – Foundation for excellence in patient care

• Frontline health care personnel are change agents
  – Leadership is essential to effect change

• Perceived benefit of innovation
  – Easily observed outcomes tend to be adopted faster

**Recognized behavior gets repeated**
Past and Present

• Increasing awareness: 1968-1980’s
• Increasing knowledge: 1990-2000
• Regulation/institutional commitment: 2000-2010
• Currently: time constraints, patient satisfaction, safety, documentation
2001—Joint Commission Pain Standards

- RI.1.2.8 “Patients have the right to appropriate assessment and management of pain.”
- Initial and ongoing pain assessment mandated
- Institutional standards for maximum acceptable pain scores recommended
- Pain assessment became the “The 5th Vital Sign”
- Patient Safety Standards
- Pain management programs evolved
- 2003—Patient Safety Goals
Results of Policy Changes

- Opioid prescriptions doubled over a decade
- 259 million opioid Rx written in 2012
- 90% of children & adolescents report recent use of analgesics to self-treat pain  
  Volkow, ND. JAMA 2011; 305: 1299
- Fatal poisonings tripled from 1999-2006
  - Approx. 14,000 accidental deaths from opioids in 2006
- 66% of unintentional overdose deaths were in patients treated for acute or chronic pain
Contributors to Problem

• Oversimplification of pain assessment
• Standardization
  – We perceive pain differently, so cannot standardize pain treatment
• Over or inappropriate use of drugs
  – Emphasized taking the drugs, but de-emphasized the risks
• Imbalanced approach to patient education regarding analgesic use
Pain is Multidimensional

- **Situational Factors**
  - Exception
  - Control
  - Relevance

- **Emotional Factors**
  - Fear
  - Anger
  - Frustration

- **Gender**
- **Age**
- **Cognitive Level**
- **Previous Pains**
- **Family Learning**
- **Culture**

- Noxious
- Stimulus

- Pain
- Sensation
Differences in Perception

• High proportion of patients with chronic pain may have centralized their pain
  – Amplified pain → hyperalgesia
  – Amplifies or dampens pain perspective
  – Opioids may worsen pain in these patients

• Pharmacogenetic differences
  – Poor metabolizers → poor analgesic response, especially in very old and very young
What is Important To The Patient?

• Pain relief and comfort
• Minimal side effects
• Improved function
• Needs and preferences met
• Has enough information to participate
• Kindness and empathy
• Discontinue or reduce opioids
Health Care That Makes A Difference

- High level provider knowledge and skill
  - Safeguard against adding pain
- Provider attitude toward pain
  - Belief in patient (empathy)
  - Assessment and re-assessment
- Provider response to patient
  - Caring, timely, attentive, informative, sensitive
  - Bedside manner: quiet, respectful, available
  - Listened

Comly, 2001, Sherwood, 2000
Pain Assessment--Another Perspective
What Is The Patient Story?

• Forms basis for setting goals and planning care
  – Includes history, current state, desired state and goals

• Story is dynamic, understood, and coordinated
  – Ask the right questions
  – Take time to actively listen
  – Include family and like-family

• If unable to speak for self, the patient’s family/like family becomes the patient’s voice
Setting Mutual Goals

- **Know** the patient’s story – needs, perspectives, fears, challenges, strengths, goals, etc.
- **Use** the patient’s story to establish shared goals, plan care, and evaluate outcomes
- **Share** the patient’s story for continuity of care (between shifts, units, home, disciplines, etc.)
Patient & Family Centered Care

• Listen to and respect each family’s values, practices and beliefs
  – Create a place where families can speak for their family member without any barriers

• Communicate and share complete information when it is available
  – View family as key member of the healthcare team

• Encourage patients/families to participate in making decisions
  – Teach patient/family how to perform care
Benefits of Patient and Family Centered Rounds

Evidence showed patient & family rounds improved:

• Communication between health care team and patient/family
• Clinical decision-making
• Adherence to care plan when developed collaboratively
• Efficient and effective use of health care resources
• Patient and family satisfaction with care
• Staff satisfaction and teamwork
Cognitive Behavioral Theory: Catastrophizing

- Exaggerated negative “mental set” during actual or anticipated pain experience

- Often creates anxiety
- Nurses need to help break the cycle
How to Break the Cycle

- Provide structure and consistency
- Realistic goals and expectations

Knowledge

Self Control

Empowerment

Redirect and focus on something else

New thoughts
Kolcaba’s Comfort Theory

Distress: 4 Contexts
- Physical
- Environmental
- Sociocultural
- Psychospiritual

Comfort Interventions: 3 Types
- Technical
- Coaching
- Comforting

Patient Outcomes
- Optimum Function
- Peaceful Death

Kolcaba, K., 2003
Pain And The Domains of Care

- Symptom management: Pain, anxiety, spasms
- Activity and function: Mobility, deep breathing
- Medication taking: Learning assessment, teaching strategies
- Nutrition: Nausea, vomiting, constipation
- Family and use of resources
- Use of the health care system
The Relationship of Pain

**Health Care Process**
- Know the patient’s story
- Set a goal for comfort, pain relief, and promotion of function
- Identify symptoms
- Individualize care
- Evaluate clinical outcomes
- Prevent worsening or future problems

**Customer Satisfaction**
- Respect me as person
- Co-ordinate care
- Give information
- Provide comfort / pain relief
- Address my fears
- Involve my family / friends
- Think of me as a person on the continuum of life—-not an episode
Indicators For Quality Pain Management

- Regular administration of analgesics
- Multimodal approach
- Patients informed about pain management
- Prescribe the lowest effect dose
- Give the quantity based on expected pain duration
- Avoid combinations of opioids and sedatives
- ATC dosing—especially in unmonitored setting is considered dangerous

Kirschnern, Ann Intern Med 2014; 160:198
Factors to Consider

- Age
- Respiratory & Sedation Status
- Opioid Tolerance
- Persistent (Chronic) Pain
- Anesthesia & Other Meds
- Type(s) of Pain
- Pain Intensity
- Underlying Pathology
- Organ Function
- Kinetics of Analgesic

Individualized Therapy

Used by Permission- C. Pasero, MS, RN-BC, FAAN (2013)
<table>
<thead>
<tr>
<th>AMPLIFIERS OF PAIN</th>
<th>DAMPENERS OF PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPIRITUAL</strong></td>
<td><strong>SOCIAL</strong></td>
</tr>
<tr>
<td>Spiritual distress</td>
<td>Socially isolated</td>
</tr>
<tr>
<td>Emotional failure</td>
<td>Relationship, role conflict</td>
</tr>
<tr>
<td>Lost connections to environment</td>
<td>Over-dependency</td>
</tr>
<tr>
<td>Dire meaning, suffering</td>
<td>Dysfunctional coping</td>
</tr>
<tr>
<td>Energy unbalance</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>MIND</strong></td>
</tr>
<tr>
<td>Emotional distress</td>
<td>Emotional distress</td>
</tr>
<tr>
<td>Sadness or anger</td>
<td>Sadness or anger</td>
</tr>
<tr>
<td>Fear, worry, frustration</td>
<td>Fear, worry, frustration</td>
</tr>
<tr>
<td>High or prolonged stress</td>
<td>High or prolonged stress</td>
</tr>
<tr>
<td>Self doubts, helplessness</td>
<td>Self doubts, helplessness</td>
</tr>
<tr>
<td>Catastrophizing</td>
<td>Catastrophizing</td>
</tr>
<tr>
<td></td>
<td><strong>NEUROLOGICAL</strong></td>
</tr>
<tr>
<td>Dermatome overstimulation</td>
<td>Dermatome overstimulation</td>
</tr>
<tr>
<td>Wind-up, sensitization</td>
<td>Wind-up, sensitization</td>
</tr>
<tr>
<td>Neuropathic changes</td>
<td>Neuropathic changes</td>
</tr>
<tr>
<td>Neuronal inflammation</td>
<td>Neuronal inflammation</td>
</tr>
<tr>
<td>Activation of microglia</td>
<td>Activation of microglia</td>
</tr>
<tr>
<td></td>
<td><strong>TISSUE</strong></td>
</tr>
<tr>
<td>Ongoing tissue damage</td>
<td>Ongoing tissue damage</td>
</tr>
<tr>
<td>Glutamate, substance P</td>
<td>Glutamate, substance P</td>
</tr>
<tr>
<td>Prostaglandin, lactic acid</td>
<td>Prostaglandin, lactic acid</td>
</tr>
<tr>
<td>Repetitive injury/strain</td>
<td>Repetitive injury/strain</td>
</tr>
<tr>
<td>Inflammation/infection, Hypoxia</td>
<td>Inflammation/infection, Hypoxia</td>
</tr>
<tr>
<td>Muscle tension/spasm</td>
<td>Muscle tension/spasm</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Strong faith</strong></td>
</tr>
<tr>
<td></td>
<td>Essence of person unchanged</td>
</tr>
<tr>
<td></td>
<td>Sustained, renewed sense of purpose</td>
</tr>
<tr>
<td></td>
<td>Environment/social contacts maintained</td>
</tr>
<tr>
<td></td>
<td>Energy flow balanced</td>
</tr>
<tr>
<td></td>
<td><strong>Socially engaging</strong></td>
</tr>
<tr>
<td></td>
<td>Meaningful, pleasurable activities</td>
</tr>
<tr>
<td></td>
<td>Effective communication</td>
</tr>
<tr>
<td></td>
<td>Work, volunteer</td>
</tr>
<tr>
<td></td>
<td>Emotional stability, feel loved</td>
</tr>
<tr>
<td></td>
<td>Self-efficacy, optimistic</td>
</tr>
<tr>
<td></td>
<td>Acceptance, realistic appraisal</td>
</tr>
<tr>
<td></td>
<td>Mental distraction</td>
</tr>
<tr>
<td></td>
<td>Mindfulness</td>
</tr>
<tr>
<td></td>
<td>Relaxation response</td>
</tr>
<tr>
<td></td>
<td><strong>Dermatome stimulation (rubbing, heat, cold)</strong></td>
</tr>
<tr>
<td></td>
<td>Production/release of endorphins</td>
</tr>
<tr>
<td></td>
<td>Tissue repair, healing</td>
</tr>
<tr>
<td></td>
<td>Tissue stimulation (rubbing, heat, cold, TENS)</td>
</tr>
<tr>
<td></td>
<td>Optimal Nutrition, oxygen</td>
</tr>
</tbody>
</table>
| | Position support (brace) | Arnstein, P. (201
## Common Words Describing Pain & Distress

<table>
<thead>
<tr>
<th>EMOTIONAL DISTRESS</th>
<th>NEUROPATHIC PAIN</th>
<th>NOCICEPTIVE PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frightening</td>
<td>Burning</td>
<td>Tender</td>
</tr>
<tr>
<td>Punishing</td>
<td>Flashing</td>
<td>Sharp, cutting</td>
</tr>
<tr>
<td>Vicious</td>
<td>Shooting</td>
<td>Dull</td>
</tr>
<tr>
<td>Annoying</td>
<td>Stabbing</td>
<td>Cramping</td>
</tr>
<tr>
<td>Nagging</td>
<td>Tingling</td>
<td>Squeezing</td>
</tr>
<tr>
<td>Unbearable</td>
<td>Prickling</td>
<td>Throbbing</td>
</tr>
</tbody>
</table>

Pain Scores and Scales

• Patient’s self-report is most reliable method for rating pain intensity
• Scales should be developmentally, physically, emotionally & cognitively appropriate for patient
• Does the score convey clinically relevant information?
  – Underestimation or overestimation could lead to inappropriate treatment decisions
• Functional goal—what pain level is acceptable to the patient?
# Guidelines for Pain Scale Use

<table>
<thead>
<tr>
<th>Scale Type</th>
<th>NEONATE</th>
<th>PEDIATRIC</th>
<th>COGNITIVELY IMPAIRED PEDS</th>
<th>ADULT</th>
<th>COGNITIVELY IMPAIRED ADULT</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numeric (0-10)</td>
<td></td>
<td>≥ 9 years</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Color Scale</td>
<td></td>
<td>≥ 7 years</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Word Scale</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Wong-Baker Faces</td>
<td></td>
<td>≥ 3 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLACC</td>
<td></td>
<td>0-18 years</td>
<td>Unconscious</td>
<td></td>
<td>Unconscious</td>
<td></td>
</tr>
<tr>
<td>rFLACC</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N-PASS</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finger Span</td>
<td></td>
<td>≥ 2.5 years</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>PAINAD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dementia</td>
<td></td>
</tr>
<tr>
<td>Assume Pain Present*</td>
<td></td>
<td>Unconscious or intubated</td>
<td>Unconscious or intubated</td>
<td></td>
<td>When unable to use other scales</td>
<td></td>
</tr>
</tbody>
</table>

* Based on physiologic observations and/or patient condition
Neurotransmitters

- Norepinephrine
- Dopamine
- Serotonin
Acute Pain

- Triggers a neuroendocrine stress response
- Lasts no more than a few months
- Resolves as underlying cause is treated
  - Usually responds to pain medications and non-pharmacological interventions
- Recent onset
- Stimulus is known injury with actual or potential tissue damage
- Usually marked effects on the autonomic nervous system
  - ↑ heart rate, ↑ blood pressure, H/A, diaphoresis, pallor
- Reversible, usually over hours to days, even healing is complete
Chronic (Non-Malignant) Pain

- Pain persisting beyond expected healing
  - Persistent pain state that may or may not be associated with long-term disease
  - The pain is now a significant disease process rather than a symptom
- Patient is now trying to adapt to the pain
  - Withdrawal and depression are common

Neuropathic Pain

- Abnormal processing of sensory input by the central or peripheral nervous system
  - Exact mechanisms involved are unclear
  - “Burning, tingling, electric, shooting”
Cancer Pain

Can be caused by:

- Disease progression
- Operative/diagnostic procedures
- Toxicities of radiation/chemo
- Infections from ongoing disease
- Psychological stress/Spiritual issues
Know Your Medications

• Peak effect and duration of opioid and sedating medication
• Effect of metabolism and excretion on drug action
  – Agents vary in onset, peak, duration
• Additive effect of drugs
• Synergistic effect of drugs
Mechanism of Action: Opioids

- Opioids bind to opiate receptors in the central nervous system
  - Inhibit the ascending pain pathways
  - Alter the perception of & response to pain

- Produce generalized central nervous system depression
  - Decrease the level of consciousness
  - Often decrease the respiratory rate
Opioid Dosing

• There is little to no analgesia until analgesic threshold is reached

• Once reached, a small increase in serum concentration produces effective analgesia

• Optimal analgesic dose varies widely

• Consider whether patient is opioid naive or not

• If pain is moderate to severe, or present most of day, give ATC, not PRN
### Opioid Peak Effect and Duration

<table>
<thead>
<tr>
<th>DRUG</th>
<th>PEAK</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl (IV)</td>
<td>5 min</td>
<td>1 hr</td>
</tr>
<tr>
<td>Morphine (IV)</td>
<td>20 min</td>
<td>4-5 hrs</td>
</tr>
<tr>
<td>Morphine (PO)</td>
<td>60 min</td>
<td>4-5 hrs</td>
</tr>
<tr>
<td>Morphine SR (PO)</td>
<td>60 min</td>
<td>8-12 hrs</td>
</tr>
<tr>
<td>Oxycontin (PO)</td>
<td>60 min</td>
<td>8-12 hrs</td>
</tr>
<tr>
<td>Oxycodone (PO)</td>
<td>60 min</td>
<td>4-5 hrs</td>
</tr>
<tr>
<td>Hydromorphone (IV)</td>
<td>15 min</td>
<td>4-5 hrs</td>
</tr>
<tr>
<td>Hydromorphone (PO)</td>
<td>30-60 min</td>
<td>4-5 hrs</td>
</tr>
<tr>
<td>Methadone (IV)</td>
<td>60 min</td>
<td>4-6 hrs</td>
</tr>
<tr>
<td>Methadone (PO)</td>
<td>30-60 min</td>
<td>6-8 hrs</td>
</tr>
</tbody>
</table>
Mechanism of Action: Benzodiazepines

- Enhances effects of neurotransmitters → sedative, hypnotic, anxiolytic, anticonvulsant & muscle relaxant
- Induces a calming effect on parts of the limbic system
  - ↓ decreases anxiety
- **Caution when using benzodiazepines with opioids → additive & synergistic effects**
  - ↑ analgesia, ↑ sedation
  - ↓ respirations and ↓ tidal exchange
  - ↑ CO₂ and ↓ response to CO₂
  - Outcome → Death
# Benzodiazepine Peak Effect & Duration

<table>
<thead>
<tr>
<th>DRUG</th>
<th>PEAK</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam (PO)</td>
<td>60 min</td>
<td>8-12 hrs</td>
</tr>
<tr>
<td>(Xanax®)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam (PO)</td>
<td>30-60 min</td>
<td>12-24 hrs</td>
</tr>
<tr>
<td>(Valium®)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam (PO)</td>
<td>30-60 min</td>
<td>8-12 hrs</td>
</tr>
<tr>
<td>(Ativan®)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydroxyzine (PO)</td>
<td>90-120 min</td>
<td>6-8 hrs</td>
</tr>
<tr>
<td>(Atarax®)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promethazine (PO)</td>
<td>60 min</td>
<td>4-6 hrs</td>
</tr>
<tr>
<td>(Phenergan®)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Characteristics Of Patients At Higher Risk For Oversedation & Respiratory Depression

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Associated Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep apnea, or sleep disorder diagnosis</td>
<td>Morbid obesity</td>
</tr>
<tr>
<td>Snoring (i.e. undiagnosed OSA)</td>
<td></td>
</tr>
<tr>
<td>No recent opioid use or opiate naive</td>
<td>Smoker</td>
</tr>
<tr>
<td>Increased opioid dose requirement, or opioid habituation</td>
<td>Post-surgery (upper abdominal &amp; thoracic surgery may impair breathing)</td>
</tr>
<tr>
<td>Receiving other sedating drugs (i.e. benzodiazepines, antihistamines, and CNS depressants)</td>
<td>Longer length of time receiving general anesthesia during surgery</td>
</tr>
<tr>
<td>Preexisting pulmonary or cardiac disease or major organ failure</td>
<td>Older age (↑risk for every decade &gt; 60) Very young age</td>
</tr>
</tbody>
</table>

TJC Sentinel Alert 49: Safe Use of Opioids in Hospitals
Remember...

Analgesia

precedes

Sedation

which precedes

Respiratory Depression
The Slippery Slope of Sedation

CONSCIOUSNESS

SEDATION SCORE (UMSS)

0  Awake

1  Minimally sedated: tired/sleepy, appropriately responds to verbal conversation and/or sounds

2  Moderately sedated: somnolent/sleeping, easily aroused with light tactile stimulation

3  Deeply sedated: deep sleep, arousable only with significant physical stimulation

4  Unarousable

UNCONSCIOUSNESS

UMSS—University of Michigan Sedation Scale
Malviya, et al, British Journal of Anaesthesia, 2002
Sedation Assessment

• Frequency, intensity and duration of sedation monitoring based on:
  – Type of opioid therapy
  – Patient risk factors
  – Response to treatment

• Awaken and rate patients sedation score using a sedation scale

• If patient asleep, and observations indicate no changes from previous assessment, chart “sleeping” and document respiratory rate and quality
Respiratory Effect of Opioids

- Opioids decrease ventilation:
  - ↓ Rate of respirations
  - ↓ Tidal volume
  - ↓ Response at CO$_2$ receptors
- Increased CO$_2$ levels don’t increase RR
- Body relies on the O$_2$ driven respiratory regulatory system—this is less sensitive
- Even smaller opiate doses can ↓ RR, minute volume, and tidal exchange
Respiratory Depression

• Decrease in respiratory rate
  – <10/minute

• Decrease in depth (quality)
  – ie, shallow, irregular, snoring, wheeze, use of accessory muscles

• ↓ Arterial O₂ content or arterial O₂ partial pressure (PaO₂)
  – SaO₂ or SpO₂ ≤ 90%
Hypoxemia vs Hypoxia

**Hypoxemia:** Insufficient O2 in blood

- ↓ Arterial O2 content or arterial O2 partial pressure (PaO2)
- SaO2 or SpO2 < 90% (adults), <94% (pediatrics)
- Baseline differences for patients with specific chronic respiratory and cardiac diseases (COPD & CHF)

**Hypoxia:** Insufficient O2 at cellular level

- Symptoms—irritability, anxiety, confusion, stupor, coma
- Can cause serious neurological or cardiac problems, leading to death
Distribution of Desaturation Events Over Time

Mean 9.6 ± 6.1

Hours from PACU DC to Desaturation Event
Assessing The Sleeping Patient

• Know the patient’s baseline
• Know conditions ↑ patient risk for opioid sedation
• Do thorough respiratory assessment
  – Is ventilation adequate?
  – Rate and quality
  – Look at patient with enough light to see
  – Poor color/cyanosis are late signs of ↓ oxygenation
• When is peak effect and duration of meds given?
Snoring is a Warning Sign...

- Snoring ≠ restful sleep
- Indicates airway obstruction
- Must be attended to promptly (Isono, Tanaka & Nishina, 2)
- May require Respiratory Therapy consultation and/or a sleep study
- Family may think it’s normal, because...
- At home...patients
  - Wake themselves up, or
  - Partner wakes them up
Transitions: Patient & Family Education

• Explain action and side effects of pain meds
  – Duration of analgesic use
  – Use of adjuvant meds

• Transitioning Off Narcotic Analgesics
  – Changing from ATC to PRN
  – Increasing time interval between meds
  – Changing to a less potent narcotic
  – Stopping narcotic

• Patient/family need to write down instructions for changes
  – Read back new changes reduces chance of error
Transitions: Challenges in Phone Management

• Unable to rely on visual cues or direct assessment skills
• Often dealing with family member’s interpretation of pain
• Language barriers, developmental delays, etc.
• Critical thinking
  – Things not always as they seem
  – Frequently need additional information
Transitions: Medication Related Challenges

- Availability of Schedule 2 Narcotics in local pharmacies
  - Availability of all routes/concentrations
- Prior authorizations for insurance
- Use of tamper proof paper
- Refills on Schedule 2 Narcotics
**Risk for Drug Abuse**

- Physician needs to do thorough evaluation
  - Determine treatment objectives and plan
  - Regular review of plan for safety, efficacy, compliance
  - Obtain consult with specialist in pain, addiction, psychiatrist if needed
- For nonmalignant pain, patient must agree:
  - Take opioids as prescribed
  - No opioid prescriptions from other doctors
  - Use the same pharmacy
  - Agree to contact police if meds or Rx is stolen
Abuse and Diversion Red Flags

- Finishing meds before they are due for refill
- Reports pain not controlled
- Frequent reports of side effects
- Lost prescriptions
- Lost or destroyed medications
- Calling different staff/providers
Who is Taking The Prescription, The Patient or Caregiver?

• Ask pharmacist for summary of prescription use
• DOCUMENT in Problem Summary List
• Document special circumstances
• Clarify prescription plan with patient and/or caregiver
• Reassess pain control with follow-up phone calls
• Schedule return clinic appointment

• Safety is key!
Why Use Non-Pharmacological Approaches?

- Patients want non-drug options
  - Introduce in combination with pharmacologic therapies
  - Scientific evidence that it works
  - Individualize based on the diagnosis

- Gives the patient power and control over pain
  - Places the patient in a more active role
  - Teaches a skill for life
  - Patients tell us they work

- Develop pain care plan patients can bring
# Personal Comfort & Pain Control Options

<table>
<thead>
<tr>
<th>Comfort Items</th>
<th>Comfort Actions</th>
<th>Personal Care</th>
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<tbody>
<tr>
<td>Warm Blankets</td>
<td>Repositioning</td>
<td>Brush Teeth</td>
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<tr>
<td>Ice Pack</td>
<td>Walk in hall</td>
<td>Lip balm</td>
</tr>
<tr>
<td>Extra pillow</td>
<td>Bath or shower</td>
<td>Deodorant</td>
</tr>
<tr>
<td>Neck pillow</td>
<td>Range of motion</td>
<td>Comb/brush</td>
</tr>
</tbody>
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## Relaxation Options

<table>
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<tr>
<th>Relaxation Options</th>
<th>Activities to Relieve Boredom</th>
<th>Let Your Caregiver Know</th>
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<td>Socks</td>
<td>Book, Magazine</td>
<td>What works at home</td>
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<tr>
<td>Ear plugs</td>
<td>Music</td>
<td>If the medication is working</td>
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<tr>
<td>Stress Ball</td>
<td>Cards</td>
<td>What to bring from home</td>
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<tr>
<td>Aromatherapy</td>
<td>Word search, puzzles</td>
<td>When to call the nurse</td>
</tr>
</tbody>
</table>
Areas for Evaluation and Future Research

How do we evaluate the success of pain management across the continuum?


